

**DOCUMENTATION of TRAINING for challenging the Nurse Aide Test:** This form is to be used for nursing students who complete the topics listed below **and** have clinical experience in geriatrics before they complete the semester nursing course(s). Please verify the individual has met the requirements, sign the attestation below and return this form along with the individual's application and fee to Health Occupations Credentialing.

\_\_\_\_\_ has successfully completed the topics listed below  
Student Name

**and** clinical experience in geriatrics.

*Requirements/Required Topics:*

- |   |  |
|---|--|
| 1. <u>Basic Skills</u><br>Communication and interpersonal skills<br>Infection control<br>Safety/emergency procedures, including<br>the Heimlich maneuver<br>Promoting resident independence<br>Respecting resident rights   | 4. <u>Basic Restorative Services</u><br>Safe use of mechanical devices<br>Normal range of motion and positioning<br>Care and use of prosthetic and orthotic<br>devices   |
| 2. <u>Basic Nursing Skills</u><br>Taking and recording vital signs<br>Measuring and recording height and<br>weight<br>Caring for the resident environment<br>Recognizing abnormal changes in body<br>functioning and the importance<br>of reporting such changes to a<br>supervisor<br>Caring for residents when death is<br>imminent | 5. <u>Mental health and social service needs</u><br>Modifying aide's behavior in response<br>to residents' behavior<br>Awareness of developmental tasks<br>associated with the aging<br>process<br>How to respond to resident behavior,<br>using the resident's family as a<br>source of emotional support |
| 3. <u>Personal Care Skills</u><br>Cleanliness and grooming<br>Nutrition and fluids<br>Lifting and moving the resident<br>Toileting<br>Skin care   | 6. <u>Care of Cognitively Impaired Residents</u><br>Communicating with cognitively<br>impaired residents   |

I do hereby attest that the information supplied on this form is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided on this form.

\_\_\_\_\_  
Nursing Department Coordinator Name (Please print.)    Signature

\_\_\_\_\_  
Telephone Number    E-mail

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School